“They were all together… discussing the best options for me”: Integrating specialist diabetes care within primary care

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Introduction:

In Australia, over a third of encounters with health care providers for patients with diabetes fail to provide clinical guideline appropriate care. The Diabetes Alliance, an integrated care model implemented across a large healthcare district, was aimed at enhancing diabetes care capacity at primary care level and has been associated with improvements in metabolic parameters[1].

The model of care implemented was

- Intensive case-conferencing with
  - the primary care team
  - patients
  - a visiting specialist team;
- Whole practice performance feedback
- Regular diabetes masterclasses.

We aimed to provide in-depth insight into the case-conferencing process that 84 practices, 343 Primary Care Physicians and 100 Practice Nurses participated in. We aimed to define the impact of this model of care had for patients with diabetes.

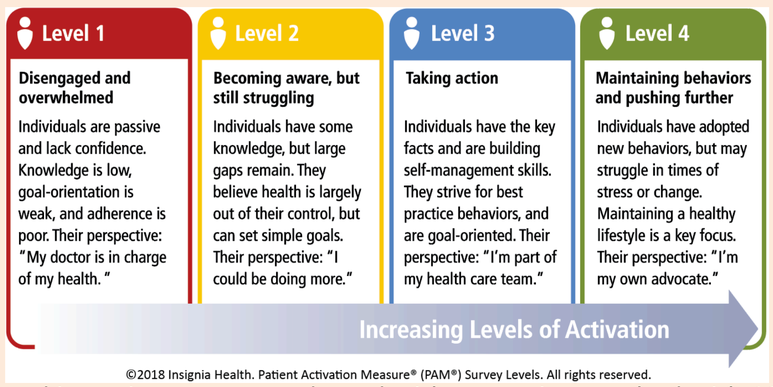
Methods:

Five practices participating in the Alliance model were selected based on proportion of patients with recent HbA1c

- 2 with high proportion
- 3 with low proportion

Patients selected from each practice based on Patient Activation Measure[2] scores to achieve maximum variation

- 1 or 2 patients with high scores
- 2 or 3 with low scores



Semi-structured interviews were conducted with saturation reached with 19 patients.

Analysis:

Thematic using the process outlined in Braun and Clark.

Results:

Key themes surrounding the positive aspects of the program emerged from the data. These included:

- Patients experienced a boost in confidence in diabetes self-management (particularly around nutrition),
- The program provided patients with an opportunity to refocus when “life gets in the way”
- The holistic approach to healthcare was viewed positively by patients
- Reduced travel time, familiarity in the environment and clinical care

Top-down knowledge transfer and mutual learning by the patient and their primary care team.

Patients also described aspects where the program could be improved as well as struggles with disease management. These included difficulties with:

- Coping with diabetes as a chronic illness
- Adhering to treatment recommendations

> “The results are probably just as good it probably if I can say probably even better because the GP is also learning, the GP is hearing from a specialist.”

> “I think having, having, with the Alliance you’ve got the doctor, the dietician and the nurse and your own doctors there it, it makes it more comfortable.”

> “…gives you more of an insight into little things that you can improve.”

> “It sort of becomes a bit of a juggling act so… there’s depression, pain management, diabetes.”

> “It made me feel that it was, um, it was going to be helpful, but the fact that ongoing care will be with those two people.”

Conclusion:

Providing timely integrated specialist care within the primary care setting is an efficient means of enhancing the engagement of diabetic patients with their diabetes care and therefore their outcomes.

1. Parsons M, Luu J, Acharya S, Philcox A. Diabetes Alliance in the Hunter and New England region. International Journal of Integrated Care. 2018;18(S1):43.
2. Hibbard JH, Stockard J, Mahoney ER, Tusler M. Development of the patient activation measure (PAM): conceptualizing and measuring activation in patients and consumers. Heath Serv Res. 2004; 39 (4 Pt 1): 1005-1026.